STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 118898-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 31ST day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On January 5, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner receives health care benefits under a group policy underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on January 24, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is the *Community Blue Group Benefits Certificate* (the certificate). Riders *CBD $5,000-NP (Nonpanel Deductible)* and *CB-CM-NP $5,000 (Nonpanel Copayment Maximum)* describe the deductible and copayment requirements for the Petitioner's health care coverage. The Commissioner reviews contractual issues pursuant to section 11(7) of the PRIRA, MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

In the early morning hours of November 15, 2009, the Petitioner fell and struck her head. Over the course of the day she began to exhibit signs of a serious head injury: headache, nausea, vomiting, and difficulty speaking. She was taken by ambulance to the emergency trauma center of the XXXXX Hospital in XXXXX, Illinois where she was diagnosed with acute subdural and temporal lobe hematoma. Surgery was performed immediately and she was then admitted to XXXXX's intensive care unit. Petitioner entered the XXXXX Hospital rehabilitation unit on November 26 and was discharged on December 23, 2009.

XXXXX Hospital participates with Blue Cross Blue Shield of Illinois. The physicians who treated the Petitioner are part of the XXXXX Association, a physician group practice that does not participate with Michigan or Illinois Blue Cross Blue Shield.

XXXXX Hospital billed BCBSM for $230,489.71 for the Petitioner's care. BCBSM processed those bills according to BCBSM's customary fee schedule and paid XXXXX Hospital $83,667.95. Because XXXXX Hospital is a Blue Cross Blue Shield participating provider, it accepted the amount paid as payment in full for the Petitioner's hospital care.

BCBSM also received bills from the XXXX Association (XXXXX). The exact amount billed by XXXXX is not clear from the documents submitted by the parties. BCBSM's final adverse determination approximates the amount in dispute at $16,281.19. The Petitioner's representative submitted a copy of an invoice from XXXXX billing the Petitioner for $15,872.19. (The final adverse determination states that, since the initial claims denials, BCBSM has agreed to pay six additional claims for anesthesia and radiology services provided in November and December 2009.) In light of the Commissioner's analysis below, it is not necessary to resolve the exact amount of XXXXX's billing.

The Petitioner, through her authorized representative, appealed BCBSM's reimbursement amount for her XXXXX-provided care through BCBSM's internal grievance process. BCBSM held a managerial-level conference on October 20, 2010, and issued a final adverse determination dated November 3, 2010.

III. ARGUMENTS OF THE PARTIES

BCBSM's Argument

BCBSM's final adverse determination cites several provisions in Part 2 and Part 4 of the certificate of coverage and notes that the Petitioner's coverage includes two riders which set her annual deductible at $5,000.00 and her annual copayment maximum at $5,000.00. In explaining its claims decisions, BCBSM's representative wrote:

> In this case, we could waive the deductible and copayment requirements applied to [Petitioner's] anesthesia and radiology services. Those services are performed by provider specialties that are exempt from the non-panel cost sharing provisions. However, we must maintain the cost sharing requirements applied to [Petitioner's] inpatient medical care, surgery, and consultations. These services were performed by nonpanel and nonparticipating providers. Thus, [Petitioner] is liable up to the billed charges.
>
> I realize that you feel that payment should be made to charge [*sic*] because you confirmed that the XXXXX Hospital was a PPO facility. Our call notes support that you were informed of this information. However, this information is correct, and it does not guarantee that the patient will not have any liability, nor does it guarantee that all services will be paid. Thus, we must uphold our decision.
>
> I also understand that you feel that [Petitioner] was treated in a "low access" area. A review online at www.bcbsm.com, under the *Out-of-state* link reveals several participating physicians/neurological surgeons affiliated with the XXXXX Hospital. Thus, we are unable to waive any further liabilities applied to the services at issue.
>
> Finally, I understand that you feel that charges should be paid because the care was emergent in nature. However, there are no circumstances that would allow us to pay **charges** under the certificate of coverage. As explained, we pay approved amounts. Furthermore, nonpanel cost share is only waived for the initial exam related to a qualifying medical emergency. These requirements are not waived for follow-up care.

Petitioner's Argument

The Petitioner's authorized representative, in the request for external review, wrote that the Petitioner was transported by ambulance to an emergency trauma center for a life threatening condition and therefore had no choice as to where her services would be provided. Following surgery she was in a coma for several days. The Petitioner and her family had no way of knowing that her physician services would be provided by nonparticipating physicians.

The Petitioner's representative also claims that in other similar cases, BCBSM has not applied the nonpanel deductible when care was provided on an emergency basis. The certificate also contains a provision that indicates when services are provided in a participating hospital by nonparticipating physicians in limited circumstances the nonpanel deductible may be waived. BCBSM has applied the deductible to many of Petitioner's services.

The Petitioner's representative believes that BCBSM is required to reimburse all of Petitioner's care as though it was provided by a participating provider.

IV. ISSUES

- Did BCBSM properly apply nonpanel deductibles and copayments for services provided by XXXXX?
- Did BCBSM provide misleading information to the Petitioner's family at the time she was admitted to the XXXXX Hospital?

V. COMMISSIONER'S ANALYSIS

This appeal involves coverage for medical care provided by physicians. This coverage is described in Section 4 of the *Community Blue* certificate of coverage. Deductible and copayment requirements are described in Section 2 of the certificate. The Petitioner's medical care involved emergency treatment and acute hospital care for an accidental injury. Treatment in a hospital emergency room is outpatient care because it is provided without the patient being admitted to the hospital. When an individual is admitted to a hospital for additional care, that care is inpatient treatment. The certificate, on page 4.9, describes this coverage:

> **Emergency Treatment**
>
> We pay for services of one or more physicians for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office. Follow-up care is not considered emergency treatment.
>
> **NOTE:** Deductible and copayments are not required for these emergency panel or nonpanel physician services.

The Petitioner received emergency treatment when she arrived at XXXXX Hospital at about 8:00 pm on November 15. The emergency physicians evaluated her and ordered her admitted to the hospital intensive care unit. She underwent surgery on November 16. The exact time of admission to the hospital is not specified in the records submitted for this review although it appears that, because of the critical nature of her injury, the Petitioner was not in the emergency department for more than a few hours.

Any medical services provided in the emergency department should be covered without imposing deductibles and copayments. The treatment the Petitioner received after her hospital admission would be, under the terminology of the certificate, "follow-up care" which would be subject to deductible and copayment requirements.

Petitioner's representative argues that BCBSM misled Petitioner and her family when it approved care at XXXXX Hospital without disclosing that the doctors providing her care were not participating providers. BCBSM denies this assertion.

Under the Patient's Right to Independent Review Act (PRIRA), the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. Resolution of the factual dispute concerning what the Petitioner's family was told cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

Finally, the Petitioner requests that the Commissioner require BCBSM to provide coverage for her care at the in-network level of coverage. However, the BCBSM-approved amount is the same for network and non-network providers in a given geographic area. The difference between network and non-network levels of coverage is in the application of deductibles and copayments. The proper application of deductibles and copayments is addressed previously.

The most significant difference between network and non-network coverage is that non-network providers are not bound to accept BCBSM payments as payments in full. The certificate, on page 4.32, describes the effect of this difference:

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial.
>
> * * *
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The Commissioner cannot require BCBSM to pay more than its approved amount for any medical treatment whether that treatment is provided within or outside the BCBSM network. Similarly, the Commissioner cannot require a medical provider to accept an insurer's payment as payment in full. To the extent that the Petitioner has requested such a resolution, that request must be denied.

VI. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of November 3, 2010, is reversed in part. BCBSM shall provide, without application of deductibles and copayments, coverage for Petitioner's medical care provided by the XXXXX Association between the time of Petitioner's arrival at the XXXXX Hospital emergency department and the time of her hospital admission for surgery on November 16, 2009. This coverage must be affected within 60 of the date of this Order. In addition, BCBSM shall, within seven (7) days of affecting coverage, provide the Commissioner with proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.